

**Hospital Statement of Cost**

Healthcare and Family Services, Bureau of Health Finance, 201 S. Grand Ave. E., Springfield, IL 62763

**General Information** Preliminary

Name of Hospital: University of Chicago-Comer Children's Hospital		Medicare Provider Number: 14-0088
Street: 5841 South Maryland Avenue		Medicaid Provider Number: 3466
City: Chicago	State: Illinois	Zip: 60637-1424
Period Covered by Statement:	From: 07/01/2014	To: 06/30/2015

**Type of Control**

Voluntary Nonprofit	Proprietary	Government (Non-Federal)	
<input type="checkbox"/> Church	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Township
<input checked="" type="checkbox"/> Corporation <input checked="" type="checkbox"/>	<input type="checkbox"/> Partnership	<input type="checkbox"/> City	<input type="checkbox"/> Hospital District
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> County	<input type="checkbox"/> Other (Specify) _____

**Type of Hospital**

<input type="checkbox"/> General Short-Term	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Cancer
<input type="checkbox"/> General Long-Term	<input type="checkbox"/> Rehabilitation	<input checked="" type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Children's Hospital

**Health Care Program**

(A Separate Report Must Be Filled Out For Each Distinct Part Unit)

<input checked="" type="checkbox"/> Medicaid Hospital <input checked="" type="checkbox"/>	<input type="checkbox"/> Medicaid Sub II Rehab	<input type="checkbox"/> DHS - Office of Rehabilitation Services
<input type="checkbox"/> Medicaid Sub I Psych	<input type="checkbox"/> Medicaid Sub III Other	<input type="checkbox"/> U of I - Division of Specialized Care for Children

**NOTE: Intentional Misrepresentation Or Falsification Of Any Information In This Cost Report May Be Punishable By Fine And / Or Imprisonment Under Federal Law**

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):**

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expense prepared by (Provider name(s) and number(s)) University of Chicago-Comer 3466 for the cost report beginning 07/01/2014 and ending 06/30/2015 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Prepared by (Signed):

Signed (Officer or Administrator of Provider(s)):

\_\_\_\_\_  
Name (Typewritten)  
Title \_\_\_\_\_ Date \_\_\_\_\_  
Firm \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
Email Address \_\_\_\_\_

\_\_\_\_\_  
Name (Typewritten)  
Title \_\_\_\_\_  
Date \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
Email Address \_\_\_\_\_

This State Agency is requesting disclosure of information that is necessary to accomplish statutory purposes as found in Section 5 of the (305 ILCS 5/) Healthcare and Family Services Code (from Ch. 23, Par. 5). Failure to provide any information on or before the due date will result in cessation of program payments. This form has been approved by the Forms Mgt. Center.

Hospital Statement of Cost / Statistical Data

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Line No.	Inpatient Statistics	Total Beds Available	Total Bed Days Available	Total Private Room Days	Total Inpatient Days Including Private Room Days	Percent Of Occupancy (Column 4 Divided By Column 2)	Number Of Admissions Excluding Newborn	Number Of Discharges Including Deaths Excluding Newborn	Average Length Of Stay By Program Excluding Newborn
<b>Part I-Hospital</b>		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics	60	21,900		15,229	69.54%		5,158	8.21
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit	20	7,300		5,190	71.10%			
6.	Coronary Care Unit	10	3,650		1,095	30.00%			
7.	Burn ICU	3	1,095		930	84.93%			
8.	Nursery Special Care	24	8,760		5,613	64.08%			
9.	Nursery ICU	47	17,155		14,301	83.36%			
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery	19	6,935		1,260	18.17%			
22.	<b>Total</b>	<b>183</b>	<b>66,795</b>		<b>43,618</b>	<b>65.30%</b>		<b>5,158</b>	<b>8.21</b>
23.	Observation Bed Days				1,995				

Line No.	Part II-Program	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1.	Adults and Pediatrics				5,607			2,320	8.73
2.	Psych								
3.	Rehab								
4.	Other (Sub)								
5.	Intensive Care Unit				3,101				
6.	Coronary Care Unit				39				
7.	Burn ICU				306				
8.	Nursery Special Care				3,420				
9.	Nursery ICU				7,777				
10.	Other								
11.	Other								
12.	Other								
13.	Other								
14.	Other								
16.	Other								
17.	Other								
18.	Other								
19.	Other								
20.	Other								
21.	Newborn Nursery				511				
22.	<b>Total</b>				<b>20,761</b>	<b>47.60%</b>		<b>2,320</b>	<b>8.73</b>

Line No.	Part III - Outpatient Statistics - Occasions of Service	Program	Total Hospital
1.	Total Outpatient Occasions of Service		

Hospital Statement of Cost / Apportionment of Ancillary Services to Health Care Programs

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2014</b> To: <b>06/30/2015</b>

Line No.	Ancillary Service Cost Centers	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Cost to Charges (Col. 1 / 2)	Total Billed I/P Charges (Gross) for Health Care Program Patients	Total Billed O/P Charges (Gross) for Health Care Program Patients	I/P Expenses Applicable to Health Care Program (Col. 3 X 4)	O/P Expenses Applicable to Health Care Program (Col. 3 X 5)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	132,079,143	482,956,706	0.273480	14,997,507		4,101,518	
2.	Recovery Room							
3.	Delivery and Labor Room	11,036,649	23,262,712	0.474435				
4.	Anesthesiology	12,709,004	165,760,364	0.076671	4,127,508		316,460	
5.	Radiology - Diagnostic	56,726,285	204,330,630	0.277620	4,464,576		1,239,456	
6.	Radiology - Therapeutic	13,742,369	128,466,070	0.106973	61,966		6,629	
7.	Nuclear Medicine							
8.	Laboratory	57,121,202	609,513,300	0.093716	17,758,841		1,664,288	
9.	Blood							
10.	Blood - Administration	18,419,942	117,851,543	0.156298	6,021,074		941,082	
11.	Intravenous Therapy							
12.	Respiratory Therapy	20,611,772	127,382,002	0.161811	23,372,719		3,781,963	
13.	Physical Therapy	10,992,352	39,962,309	0.275068	1,292,418		355,503	
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	23,065,244	134,277,924	0.171772	274,056		47,075	
17.	EEG	5,658,390	32,949,689	0.171728	2,453,107		421,267	
18.	Med. / Surg. Supplies	24,269,103	92,152,375	0.263358	1,347,736		354,937	
19.	Drugs Charged to Patients	112,634,062	772,716,910	0.145764	24,016,849		3,500,792	
20.	Renal Dialysis	5,577,947	25,159,556	0.221703	510,613		113,204	
21.	Ambulance	1,124,468	4,814	233.582883	1,553		362,754	
22.	Brace and Plaster Rm	451,609	1,098,839	0.410987	4,984		2,048	
23.	Kidney Acquisition	4,907,077	5,707,147	0.859813				
24.	Liver Acquisition	3,558,742	3,787,873	0.939509	619,683		582,198	
25.	Heart Acquisition	2,942,466	4,318,238	0.681404	126,230		86,014	
26.	Pancreas Acquisition	1,268,305						
27.	Implants Dev. Charged	45,475,839	197,339,283	0.230445	4,683,224		1,079,226	
28.	Lung Acquisition	2,743,572	2,907,821	0.943515				
29.	Cardiac Rehab	195,332	1,110,571	0.175884				
30.	CT Scan	8,434,571	253,211,743	0.033310	2,368,007		78,878	
31.	MRI	7,792,162	116,973,103	0.066615	2,077,512		138,393	
32.	Cardiac Cath	6,781,345	77,834,341	0.087125	3,225,582		281,029	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
<b>Outpatient Service Cost Centers</b>								
43.	Clinic	170,320,189	358,165,081	0.475535	3,086,286		1,467,637	
44.	Emergency	33,872,272	213,646,200	0.158544				
45.	Observation	13,038,597	33,351,489	0.390945				
46.	<b>Total</b>				<b>116,892,031</b>		<b>20,922,351</b>	

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to CMS 2552, W/S C charges to recompute the department cost to charge ratio.

Hospital Statement of Cost / Computation of Inpatient Operating Cost

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Program Inpatient Operating Cost

Line No.	Description	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. a)	Adjusted general inpatient routine service cost (net of swing bed and private room cost differential) (see instructions)	26,928,376			
b)	Total inpatient days including private room days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	17,224			
c)	Adjusted general inpatient routine service cost per diem (Line 1a / 1b)	1,563.42			
2.	Program general inpatient routine days (BHF Page 2, Part II, Col. 4)	5,607			
3.	Program general inpatient routine cost (Line 1c X Line 2)	8,766,096			
4.	Average per diem private room cost differential (BHF Supplement No. 1, Part II, Line 6)				
5.	Medically necessary private room days applicable to the program (BHF Page 2, Pt. II, Col. 3)				
6.	Medically necessary private room cost applicable to the program (Line 4 X Line 5)				
7.	Total program inpatient routine service cost (Line 3 + Line 6)	8,766,096			

Line No.	Description	Total Dept. Costs (CMS 2552-10, W/S C, Pt. 1, Col. 1)	Total Days (CMS 2552-10, W/S S-3, Part 1, Col. 8)	Average Per Diem (Col. A / Col. B)	Program Days (BHF Page 2, Part II, Col. 4)	Program Cost (Col. C x Col. D)
		(A)	(B)	(C)	(D)	(E)
8.	Intensive Care Unit	12,624,441	5,190	2,432.45	3,101	7,543,027
9.	Coronary Care Unit	3,599,860	1,095	3,287.54	39	128,214
10.	Burn ICU	2,160,094	930	2,322.68	306	710,740
11.	Nursery Special Care	6,590,219	5,613	1,174.10	3,420	4,015,422
12.	Nursery ICU	32,888,356	14,301	2,299.72	7,777	17,884,922
13.	Other					
14.	Other					
15.	Other					
16.	Other					
17.	Other					
18.	Other					
19.	Other					
20.	Other					
21.	Other					
22.	Other					
23.	Nursery	1,419,557	1,260	1,126.63	511	575,708
24.	Program inpatient ancillary care service cost (BHF Page 3, Col. 6, Line 46)					20,922,351
25.	<b>Total Program Inpatient Operating Costs (Sum of Lines 7 through 24)</b>					<b>60,546,480</b>

**Hospital Statement of Cost Apportionment of Cost of Services Rendered by Interns and Residents Not in an Approved Teaching Program**  
 Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Line No.	Hospital Inpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Average Cost Per Day (Col. 2 / Col. 3)	Program Inpatient Days (BHF Page 2, Part II, Column 4)	Program Inpatient Expenses (Col. 4 X Col. 5)
		(1)	(2)	(3)	(4)	(5)	(6)
1.	Total Cost of Svcs. Rendered	100%					
2.	Adults and Pediatrics (General Service Care)						
3.	Psych						
4.	Rehab						
5.	Other (Sub)						
6.	Intensive Care Unit						
7.	Coronary Care Unit						
8.	Burn ICU						
9.	Nursery Special Care						
10.	Nursery ICU						
11.	Other						
12.	Other						
13.	Other						
14.	Other						
15.	Other						
16.	Other						
17.	Other						
18.	Other						
19.	Other						
20.	Other						
21.	Nursery						
22.	Subtotal Inpatient Care Svcs. (Lines 2 through 21)						

Line No.	Hospital Outpatient Services	Percent of Assignable Time (CMS 2552-10, W/S D-2, Col. 1)	Expense Allocation (CMS 2552-10, W/S D-2, Col. 2)	Total Dept. Charges (CMS 2552-10, W/S C, Pt.1, Lines 88-93)	Ratio of Cost to Charges (Col. 2 / Col. 3)	Program Charges (BHF Page 3, Cols. 4-5, Lines 43-45)		Program Expenses (Col. 4 X Cols. 5A-B)	
						Inpatient	Outpatient	Inpatient	Outpatient
		(1)	(2)	(3)	(4)	(5A)	(5B)	(6A)	(6B)
23.	Clinic								
24.	Emergency								
25.	Observation								
26.	Subtotal Outpatient Care Svcs. (Lines 23 through 25)								
27.	<b>Total (Sum of Lines 22 and 26)</b>								

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2014</b> To: <b>06/30/2015</b>

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of Professional Component to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	<b>Inpatient Ancillary Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
1.	Operating Room							
2.	Recovery Room							
3.	Delivery and Labor Room							
4.	Anesthesiology							
5.	Radiology - Diagnostic							
6.	Radiology - Therapeutic							
7.	Nuclear Medicine							
8.	Laboratory							
9.	Blood							
10.	Blood - Administration							
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG							
17.	EEG							
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis							
21.	Ambulance							
22.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan							
31.	MRI							
32.	Cardiac Cath							
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Cost Centers</b>							
43.	Clinic							
44.	Emergency							
45.	Observation							
46.	<b>Ancillary Total</b>							

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the professional component to total charge ratio.

Hospital Statement of Cost / Analysis of Hospital - Based Physician Expense

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2014</b> To: <b>06/30/2015</b>

Line No.	Cost Centers	Professional Component (CMS 2552-10, W/S A-8-2, Col. 4)	Total Days Including Private (CMS 2552-10, W/S S-3 Pt. 1, Col. 8)	Professional Component Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for H B P (Col. 3 X Col. 4)	Outpatient Program Expenses for H B P (Col. 3 X Col. 5)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics							
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit							
52.	Coronary Care Unit							
53.	Burn ICU							
54.	Nursery Special Care							
55.	Nursery ICU							
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	<b>Routine Total (lines 47-66)</b>							
68.	<b>Ancillary Total (from line 46)</b>							
69.	<b>Total (Lines 67-68)</b>							

**Hospital Statement of Cost  
Computation of Lesser of Reasonable Cost or Customary Charges**

Preliminary

<b>Medicare Provider Number:</b> 14-0088		<b>Medicaid Provider Number:</b> 3466	
<b>Program:</b> Medicaid Hospital		<b>Period Covered by Statement:</b> From: 07/01/2014 To: 06/30/2015	
Line No.	Reasonable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Ancillary Services (BHF Page 3, Line 46, Col. 7)		
2.	Inpatient Operating Services (BHF Page 4, Line 25)	60,546,480	
3.	Interns and Residents Not in an Approved Teaching Program (BHF Page 5, Line 27, Cols. 6a and 6b)		
4.	Hospital Based Physician Services (BHF Page 6, Line 69, Cols. 6 & 7)		
5.	Services of Teaching Physicians (BHF Supplement No. 1, Part 1C, Lines 7 and 8)		
6.	Graduate Medical Education (BHF Supplement No. 2, Cols. 6 and 7, Line 69)	3,577,740	
7.	<b>Total Reasonable Cost of Covered Services (Sum of Lines 1 through 6)</b>	<b>64,124,220</b>	
8.	Ratio of Inpatient and Outpatient Cost to Total Cost (Line 7 Divided by Sum of Line 7, Cols. 1 and 2)	100.00%	

Line No.	Customary Charges	Program Inpatient	Program Outpatient
		(1)	(2)
9.	Ancillary Services (See Instructions)	116,892,031	
10.	Inpatient Routine Services (Provider's Records)		
	A. Adults and Pediatrics	18,759,075	
	B. Psych		
	C. Rehab		
	D. Other (Sub)		
	E. Intensive Care Unit	27,173,781	
	F. Coronary Care Unit		
	G. Burn ICU	2,435,485	
	H. Nursery Special Care	12,592,262	
	I. Nursery ICU	52,015,575	
	J. Other		
	K. Other		
	L. Other		
	M. Other		
	N. Other		
	O. Other		
	P. Other		
	Q. Other		
	R. Other		
	S. Other		
	T. Nursery	1,619,528	
11.	Services of Teaching Physicians (Provider's Records)		
12.	<b>Total Charges for Patient Services (Sum of Lines 9 through 11)</b>	<b>231,487,737</b>	
13.	Excess of Customary Charges Over Reasonable Cost (Line 12 Minus Line 7, Sum of Cols. 1 through 2)		167,363,517
14.	Excess of Reasonable Cost Over Customary Charges (Line 7, Sum of Cols. 1 through 2, Minus Line 12)		
15.	Excess Reasonable Cost Applicable to Inpatient and Outpatient (Line 8, Each Column X Line 14)		

Hospital Statement of Cost / Computation of Allowable Cost

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Line No.	Allowable Cost	Program Inpatient	Program Outpatient
		(1)	(2)
1.	Total Reasonable Cost of Covered Services (BHF Page 7, Line 7, Cols. 1 & 2)	64,124,220	
2.	Excess Reasonable Cost (BHF Page 7, Line 15, Columns 1 & 2)		
3.	Total Current Cost Reporting Period Cost (Line 1 Minus Line 2)	64,124,220	
4.	Recovery of Excess Reasonable Cost Under Lower of Cost or Charges (BHF Page 9, Part III, Line 4, Cols. 2B & 3B)		
5.	Protested Amounts (Nonallowable Cost Items) In Accordance With CMS Pub. 15-II, Ch. 1, Sec. 115.2		
6.	<b>Total Allowable Cost</b> <b>(Sum of Lines 3 and 4, Plus or Minus Line 5)</b>	<b>64,124,220</b>	

Line No.	Total Amount Received / Receivable	Program Inpatient	Program Outpatient
		(1)	(2)
7.	Amount Received / Receivable From:		
	A. State Agency		
	B. Other (Patients and Third Party Payors)		
8.	Total Amount Received / Receivable (Sum of Lines 7A and 7B)		
9.	<b>Balance Due Provider / (State Agency) *</b> <b>(Line 6 Minus Line 8)</b>		

\* Line 9 DOES NOT APPLY to the Medicaid program.

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

**Part I - Computation of Recovery of Excess Reasonable Cost Under Lower of Cost or Charges**

Line No.	(Do Not Complete This Part In Any Cost Reporting Period In Which Costs Are Unreimbursed Under 42 CFR Section 405.460) (Limitation on Coverage of Costs)	
1.	Excess of Customary Charges Over Reasonable Cost (BHF Page 7, Line 13)	167,363,517
2.	Carry Over of Excess Reasonable Cost (Must Equal Part II, Line 1, Col. 5)	
3.	Recovery of Excess Reasonable Cost (Lesser of Line 1 or 2)	

**Part II - Computation of Carry Over of Excess Reasonable Cost Under Lower of Cost or Charges**

Line No.	Description	Prior Cost Reporting Period Ended			Current Cost Reporting Period (4)	Sum of Columns 1 - 4 (5)
		to (1)	to (2)	to (3)		
		(1)	(2)	(3)		
1.	Carry Over - Beginning of Current Period					
2.	Recovery of Excess Reasonable Cost (Part I, Line 3)					
3.	Excess Reasonable Cost - Current Period (BHF Page 7, Line 14)					
4.	Carry Over - End of Current Period (Line 1 Minus Line 2 or Plus Line 3)					

**Part III - Allocation of Recovered Excess Reasonable Cost Under Lower of Cost or Charges**

Line No.	Description	Total (Part II, Cols. 1-3, Line 2) (1)	Inpatient		Outpatient	
			Ratio (2A)	Amount (Col. 1x2A) (2B)	Ratio (3A)	Amount (Col. 1x3A) (3B)
			(2A)	(2B)	(3A)	(3B)
1.	Cost Report Period ended					
2.	Cost Report Period ended					
3.	Cost Report Period ended					
4.	<b>Total (Sum of Lines 1 - 3)</b>					

**Hospital Statement of Cost  
Teaching Physicians / Routine Services Questionnaire**

BHF Supplement No. 1

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

**Part I - Apportionment of Cost for the Services of Teaching Physicians**

**Part A. Cost of Physicians Direct Medical and Surgical Services**

1. Physicians on hospital staff average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 1, Line 3)	
2. Physicians on medical school faculty average per diem (CMS 2552-10, Supplemental W/S D-5, Part II, Col. 2, Line 3)	
3. Total Per Diem (Line 1 Plus Line 2)	

**Part B. Program Data**

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
4. Program inpatient days (BHF Page 2, Part II, Column 4)				
5. Program outpatient occasions of service (BHF Page 2, Part III, Line 1)				

**Part C. Program Cost**

	General Service	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
6. Program inpatient cost (Line 4 X Line 3) (to BHF Page 7, Col. 1, Line 5)				
7. Program outpatient cost (Line 5 X Line 3) (to BHF Page 7, Col. 2, Line 5)				

**Part II - Routine Services Questionnaire**

	Adults and Pediatrics	Sub I Psych	Sub II Rehab	Sub III Other (Sub)
1. Gross Routine Revenues				
(A) General inpatient routine service charges (Excluding swing bed charges) (CMS 2552-10, W/S D - 1, Part I, Line 28)				
(B) Routine general care semi-private room charges (Excluding swing bed charges)(CMS 2552-10, W/S D - 1, Part I, Line 30)				
(C) Private room charges (A Minus B) or (CMS 2552-10, W/S D-1, Part 1, Line 29)				
2. Routine Days				
(A) Semi-private general care days (CMS 2552-10, W/S D - 1, Part I, Line 4)				
(B) Private room days (CMS 2552-10, W/S D - 1, Part I, Line 3)				
3. Private room charge per diem (1C Divided by 2B) or (CMS 2552-10, W/S D-1, Part 1, Line 32)				
4. Semi-private room charge per diem (1B Divided by 2A) or (CMS 2552-10, W/S D-1, Part 1, Line 33)				
5. Private room charge differential per diem (Line 3 Minus Line 4) or (CMS 2552-10, W/S D-1, Part 1, Line 34)				
6. Private room cost differential (To BHF Page 4, Line 4) ((Line 5 X (CMS 2552-10, W/S D-1, Part I, Line 27) Divided by (Line 1A Above))				
7. Private room cost differential adjustment (Line 2B X Line 6)				
8. General inpatient routine service cost (net of swing bed and private room cost differential) (CMS 2552-10, W/S D-1, Part I, Line 37)				
9. Adjusted general inpatient routine service cost per diem (Line 8 Divided by the Sum of Lines 2A + 2B) (to BHF Page 4, Line 1c)				

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(a)

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2014</b> To: <b>06/30/2015</b>

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Dept. Charges (CMS 2552-10, W/S C, Pt. 1, Col. 8)*	Ratio of G M E Cost to Charges (Col. 1 / Col. 2)	Inpatient Program Charges (BHF Page 3, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	Inpatient Ancillary Centers	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Operating Room	8,095,384	482,956,706	0.016762	14,997,507		251,388	
2.	Recovery Room							
3.	Delivery and Labor Room	2,556,184	23,262,712	0.109883				
4.	Anesthesiology	5,409,711	165,760,364	0.032636	4,127,508		134,705	
5.	Radiology - Diagnostic	3,385,865	204,330,630	0.016571	4,464,576		73,982	
6.	Radiology - Therapeutic	800,906	128,466,070	0.006234	61,966		386	
7.	Nuclear Medicine							
8.	Laboratory	4,436,155	609,513,300	0.007278	17,758,841		129,249	
9.	Blood							
10.	Blood - Administration	28,775	117,851,543	0.000244	6,021,074		1,469	
11.	Intravenous Therapy							
12.	Respiratory Therapy							
13.	Physical Therapy							
14.	Occupational Therapy							
15.	Speech Pathology							
16.	EKG	417,238	134,277,924	0.003107	274,056		851	
17.	EEG	594,685	32,949,689	0.018048	2,453,107		44,274	
18.	Med. / Surg. Supplies							
19.	Drugs Charged to Patients							
20.	Renal Dialysis	95,917	25,159,556	0.003812	510,613		1,946	
21.	Ambulance							
22.	Brace and Plaster Rm							
23.	Kidney Acquisition							
24.	Liver Acquisition							
25.	Heart Acquisition							
26.	Pancreas Acquisition							
27.	Implants Dev. Charged							
28.	Lung Acquisition							
29.	Cardiac Rehab							
30.	CT Scan	479,584	253,211,743	0.001894	2,368,007		4,485	
31.	MRI	100,712	116,973,103	0.000861	2,077,512		1,789	
32.	Cardiac Cath	508,359	77,834,341	0.006531	3,225,582		21,066	
33.	Other							
34.	Other							
35.	Other							
36.	Other							
37.	Other							
38.	Other							
39.	Other							
40.	Other							
41.	Other							
42.	Other							
	<b>Outpatient Ancillary Centers</b>							
43.	Clinic	7,519,882	358,165,081	0.020996	3,086,286		64,800	
44.	Emergency	2,349,963	213,646,200	0.010999				
45.	Observation							
46.	<b>Ancillary Total</b>						<b>730,390</b>	

\* If Medicare claims billed net of professional component, total hospital professional component charges must be added to W/S C charges to recompute the G M E cost to total charge ratio.

Hospital Statement of Cost / Graduate Medical Education Expense

BHF Supplement No. 2(b)

Preliminary

Medicare Provider Number: <b>14-0088</b>	Medicaid Provider Number: <b>3466</b>
Program: <b>Medicaid Hospital</b>	Period Covered by Statement: From: <b>07/01/2014</b> To: <b>06/30/2015</b>

Line No.	Cost Centers	G M E Cost (CMS 2552-10, W/S B, Pt. 1, Col. 25)	Total Days Including Private (CMS 2552-10, W/S S-3, Pt. 1, Col. 8)	GME Cost Per Diem (Col. 1 / Col. 2)	Program Days Including Private (BHF Pg. 2 Pt. II, Col. 4)	Outpatient Program Charges (BHF Page 3, Col. 5)	Inpatient Program Expenses for G M E (Col. 3 X Col. 4)	Outpatient Program Expenses for G M E (Col. 3 X Col. 5)
	<b>Routine Service Cost Centers</b>	<b>(1)</b>	<b>(2)</b>	<b>(3)</b>	<b>(4)</b>	<b>(5)</b>	<b>(6)</b>	<b>(7)</b>
47.	Adults and Pediatrics	2,948,218	17,224	171.17	5,607		959,750	
48.	Psych							
49.	Rehab							
50.	Other (Sub)							
51.	Intensive Care Unit	934,126	5,190	179.99	3,101		558,149	
52.	Coronary Care Unit	417,568	1,095	381.34	39		14,872	
53.	Burn ICU	129,488	930	139.23	306		42,604	
54.	Nursery Special Care	28,775	5,613	5.13	3,420		17,545	
55.	Nursery ICU	2,306,800	14,301	161.30	7,777		1,254,430	
56.	Other							
57.	Other							
58.	Other							
59.	Other							
60.	Other							
61.	Other							
62.	Other							
63.	Other							
64.	Other							
65.	Other							
66.	Nursery							
67.	<b>Routine Total (lines 47-66)</b>						<b>2,847,350</b>	
68.	<b>Ancillary Total (from line 46)</b>						<b>730,390</b>	
69.	<b>Total (Lines 67-68)</b>						<b>3,577,740</b>	

**Hospital Statement of Cost  
Reconciliation of Patient Days and Revenue**

Preliminary

Medicare Provider Number: 14-0088	Medicaid Provider Number: 3466
Program: Medicaid Hospital	Period Covered by Statement: From: 07/01/2014 To: 06/30/2015

Inpatient Reconciliation	Provider's Records	Adjustments	Audited Cost Report
Adult Days	20,250		20,250
Newborn Days	511		511
Total Inpatient Revenue	231,487,737		231,487,737
Ancillary Revenue	116,892,031		116,892,031
Routine Revenue	114,595,706		114,595,706
Inpatient Received and Receivable			
Outpatient Reconciliation			
Outpatient Occasions of Service			
Total Outpatient Revenue			
Outpatient Received and Receivable			

**Notes:**

Room & Board costs split between Acute and Children's Hospital.

Observation Bed Days were adjusted by 1 to agree with the as filed W/S S-3 and split between Acute and Children's Hospital

BHF Page 3 - total costs agree with W/S C Part 1, column 1

GME costs were adjusted to as filed W/S B Part 1, column 25 and split between Acute and Children's Hospital.

Room & Board and GME costs were split for Adults & Peds, ICU, CCU, Burn ICU, and Nursery.